

		FOR OHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0037614</u>			II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																		
Facility Name: <u>GROUP HOME #3</u>			I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/2004</u> to <u>06/30/2005</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																																																		
Address: <u>302 BACHMAN LANE</u> <u>GODFREY</u> <u>62035</u>			Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																																		
Number City Zip Code																																																					
County: <u>MADISON</u>																																																					
Telephone Number: <u>(618)466-0367</u> Fax # ()																																																					
IDPA ID Number: <u>37-0765971001</u>																																																					
Date of Initial License for Current Owners: <u>12/20/91</u>																																																					
Type of Ownership:																																																					
<table><tr><td><input checked="" type="checkbox"/></td><td>VOLUNTARY, NON-PROFIT</td><td><input type="checkbox"/></td><td>PROPRIETARY</td><td><input type="checkbox"/></td><td>GOVERNMENTAL</td></tr><tr><td><input checked="" type="checkbox"/></td><td>Charitable Corp.</td><td><input type="checkbox"/></td><td>Individual</td><td><input type="checkbox"/></td><td>State</td></tr><tr><td><input type="checkbox"/></td><td>Trust</td><td><input type="checkbox"/></td><td>Partnership</td><td><input type="checkbox"/></td><td>County</td></tr><tr><td></td><td></td><td><input type="checkbox"/></td><td>Corporation</td><td><input type="checkbox"/></td><td>Other</td></tr><tr><td></td><td></td><td><input type="checkbox"/></td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td><input type="checkbox"/></td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td><input type="checkbox"/></td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td><input type="checkbox"/></td><td>Other</td><td></td><td></td></tr></table>			<input checked="" type="checkbox"/>	VOLUNTARY, NON-PROFIT	<input type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL	<input checked="" type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State	<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County			<input type="checkbox"/>	Corporation	<input type="checkbox"/>	Other			<input type="checkbox"/>	"Sub-S" Corp.					<input type="checkbox"/>	Limited Liability Co.					<input type="checkbox"/>	Trust					<input type="checkbox"/>	Other					
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		<input type="checkbox"/>	Other																																																		
IRS Exemption Code <u>501(c)(3)</u>																																																					
In the event there are further questions about this report, please contact:																																																					
Name: <u>BRENDA MILLER</u>			Telephone Number: <u>(618)466-0367</u>																																																		
			<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Type or Print Name) <u>MARTHA WARFORD</u></td><td></td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Title) <u>EXECUTIVE DIRECTOR</u></td><td></td></tr><tr><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>KIMBERLY S. LOY, CPA</u> <u>PRINCIPAL</u></td><td></td></tr><tr><td>(Firm Name & Address) <u>SCHEFFEL & COMPANY, P.C.</u> <u>106 COUNTY ROAD, JERSEYVILLE, IL 62052</u></td><td></td></tr><tr><td>(Telephone) <u>(618)498-6841</u> Fax # <u>(618)498-6842</u></td><td></td></tr><tr><td colspan="3"></td><td colspan="3">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td></tr></table>			Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>MARTHA WARFORD</u>		Paid Preparer	(Title) <u>EXECUTIVE DIRECTOR</u>		(Signed) _____	(Date) _____	(Print Name and Title) <u>KIMBERLY S. LOY, CPA</u> <u>PRINCIPAL</u>		(Firm Name & Address) <u>SCHEFFEL & COMPANY, P.C.</u> <u>106 COUNTY ROAD, JERSEYVILLE, IL 62052</u>		(Telephone) <u>(618)498-6841</u> Fax # <u>(618)498-6842</u>					MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																												
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Facility Name & ID Number GROUP HOME #3

0037614 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,840</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,840</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	<u>5,327</u>	<u>365</u>		<u>5,692</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>5,327</u>	<u>365</u>		<u>5,692</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 97.47%

D. How many bed-hold days during this year were paid by the Department?
129 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☒ NO ☒

I. On what date did you start providing long term care at this location?
Date started 12/20/91

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 12/20/91 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 06/30/05 Fiscal Year: 06/30/05

* All facilities other than governmental must report on the accrual basis.

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total						
	A. General Services	1	2	3	4	5	6	7	8	9	10
1	Dietary	27,997	1,138		29,135		29,135		29,135		1
2	Food Purchase		21,366		21,366		21,366		21,366		2
3	Housekeeping	18,055	1,589		19,644		19,644		19,644		3
4	Laundry										4
5	Heat and Other Utilities			10,864	10,864		10,864		10,864		5
6	Maintenance	22,087	1,233	1,326	24,646		24,646		24,646		6
7	Other (specify):* SAFETY/SECURITY	1,521	52	5,468	7,041		7,041		7,041		7
8	TOTAL General Services	69,660	25,378	17,658	112,696		112,696		112,696		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	226,301	3,167		229,468	(4,584)	224,884		224,884		10
10a	Therapy			929	929		929		929		10a
11	Activities		695		695		695		695		11
12	Social Services			2,290	2,290		2,290		2,290		12
13	CNA Training					4,584	4,584		4,584		13
14	Program Transportation	4,964		2,905	7,869	(71)	7,798		7,798		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	231,265	3,862	6,124	241,251	(71)	241,180		241,180		16
	C. General Administration										
17	Administrative	22,838		119	22,957		22,957		22,957		17
18	Directors Fees										18
19	Professional Services			15,183	15,183		15,183		15,183		19
20	Dues, Fees, Subscriptions & Promotions			3,037	3,037		3,037		3,037		20
21	Clerical & General Office Expenses	26,358	2,029	1,540	29,927		29,927		29,927		21
22	Employee Benefits & Payroll Taxes			81,909	81,909		81,909		81,909		22
23	Inservice Training & Education			752	752		752		752		23
24	Travel and Seminar			254	254		254		254		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			49,404	49,404		49,404		49,404		26
27	Other (specify):*										27
28	TOTAL General Administration	49,196	2,029	152,198	203,423		203,423		203,423		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	350,121	31,269	175,980	557,370	(71)	557,299		557,299		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			16,216	16,216		16,216		16,216			30
31	Amortization of Pre-Op. & Org.			1,136	1,136		1,136		1,136			31
32	Interest			36,812	36,812		36,812		36,812			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* MORTGAGE INS			2,862	2,862		2,862		2,862			36
37	TOTAL Ownership			57,026	57,026		57,026		57,026			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					71	71		71			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,768	38,768		38,768		38,768			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			38,768	38,768	71	38,839		38,839			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	350,121	31,269	271,774	653,164		653,164		653,164			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>REAL ESTATE TAXES</u>				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.	X		\$ 71	14-3	38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 71		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
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33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Summary A

06/30/2005

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		BEVERLY FARM FOUNDATION	GODFREY, IL			
		GROUP HOME #1	GODFREY, IL			
		GROUP HOME #2	GODFREY, IL			
		GROUP HOME #4	GODFREY, IL			
		GROUP HOME #5	GODFREY, IL			
		GROUP HOME #6	GODFREY, IL			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V		\$			\$	\$		1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$			\$	\$ *		14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related Long-Term													
1	IL HEALTH FACILITY		X	CONSTRUCTION		07/96	\$	537,538	2031	6.6800	\$	36,180	1	
2													2	
3													3	
4													4	
5													5	
	Working Capital													
6	MISCELLANEOUS		X	WORKING CAPITAL								632	6	
7													7	
8													8	
9	TOTAL Facility Related						\$	537,538				\$	36,812	9
	B. Non-Facility Related*													
10													10	
11													11	
12													12	
13													13	
14	TOTAL Non-Facility Related						\$					\$		14
15	TOTALS (line 9+line14)						\$	537,538				\$	36,812	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 2,862 Line # 36-3

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2004 report.		\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$		2
3. Under or (over) accrual (line 2 minus line 1).		\$		3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$		7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2000		8	
	2001		9	
	2002		10	
	2003		11	
	2004		12	

	FOR OHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2004 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$	16

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

GROUP HOME #3

COUNTY

MADISON

FACILITY IDPH LICENSE NUMBER

0037614

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ()

FAX #: ()

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2004

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.			\$	\$
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$	\$

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16			1992	\$ 315,358	\$ 7,884	40	\$ 7,884	\$	\$ 106,434	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	BUS SHELTER			1996	188		5			188	9
10	ADMINISTRATION BUILDING			1997	55,609	1,390	40	1,390		11,819	10
11	HARDWARE			1998	546	55	10	55		384	11
12	SECURITY SYSTEM			1998	171	17	10	17		118	12
13	FIRE ALARM PANEL			2002	76	8	10	8		20	13
14	DIGITAL THERMOMETER			2003	778	77	10	77		193	14
15	DOOR			2003	664	66	10	66		99	15
16	TILE FLOORING - SWITCHBOARD AREA			2005	63	3	10	3		3	16
17	REPLACE CONCRETE PORCH			2005	4,447	222	10	222		222	17
18	TRAINING BUILDING ALLOCATION			1998	1,481	97	15	97		680	18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$379,381	\$9,819		\$9,819	\$	\$120,160	70

**Improvement type must be detailed in order for the cost report to be considered complete

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 15,854	\$ 2,410	\$ 2,410	\$	5-10	\$ 10,456	71
72	Current Year Purchases	3,527	353	353		5	353	72
73	Fully Depreciated Assets	58,145					58,145	73
74								74
75	TOTALS	\$ 77,526	\$ 2,763	\$ 2,763	\$		\$ 68,954	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	SEE ATTACHED SCHEDULE			\$ 36,219	\$ 3,634	\$ 3,634	\$		\$ 18,170	76
77										77
78										78
79										79
80	TOTALS			\$ 36,219	\$ 3,634	\$ 3,634	\$		\$ 18,170	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 498,126	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 16,216	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 16,216	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 207,284	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease.

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO

16. Rental Amount for movable equipment: \$
- Description:
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	\$
13.	/2007	\$
14.	/2008	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?	<input checked="" type="checkbox"/> YES	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
	<input type="checkbox"/> NO	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER CNA <u>80</u>
		HOURS PER CNA <u>64</u>	

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		100		100
3	Classroom Wages (a)		1,830		1,830
4	Clinical Wages (b)		2,288		2,288
5	In-House Trainer Wages (c)		366		366
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 4,584	\$	\$ 4,584
10	SUM OF line 9, col. 1 and 2 (e)	\$ 4,584			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	4

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,119,882		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,119,882	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,000		13
14	Buildings, at Historical Cost	379,381		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	113,745		16
17	Accumulated Depreciation (book methods)	(207,284)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 290,842	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,410,724	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	537,538		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 537,538	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 537,538	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 873,186	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,410,724	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 885,832	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 885,832	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(12,646)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (12,646)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 873,186	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **GROUP HOME #3** # **0037614** Report Period Beginning: **07/01/2004** Ending: **06/30/2005**

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 640,466	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 640,466	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	IDHFS TRANSPORTATION REIMBURSEMENT	52	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 52	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 640,518	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	112,696	31
32	Health Care	241,251	32
33	General Administration	203,423	33
	B. Capital Expense		
34	Ownership	57,026	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	38,768	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 653,164	40
41	Income before Income Taxes (line 30 minus line 40)**	(12,646)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (12,646)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	19,195	20,949	201,168	9.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	2,730	3,070	27,997	9.12	15
16	Dishwashers					16
17	Maintenance Workers	1,736	1,949	22,087	11.33	17
18	Housekeepers	2,054	2,054	18,055	8.79	18
19	Laundry					19
20	Administrator	692	707	14,963	21.16	20
21	Assistant Administrator	96	104	3,115	29.95	21
22	Other Administrative	288	314	5,476	17.44	22
23	Office Manager					23
24	Clerical	1,965	2,219	25,641	11.56	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,968	2,080	25,134	12.08	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) SEE SCHEDULE	640	673	6,485	9.64	33
34	TOTAL (lines 1 - 33)	31,364	34,119	\$ 350,121 *	\$ 10.26	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	24	\$ 929	10a-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	83	2,290	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	107	\$ 3,219		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

(See instructions.)

[illegible]

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. ILLINOIS HEALTH CARE \$829
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 38,768
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? YES If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? NO Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? YES If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 52
c. What percent of all travel expense relates to transportation of nurses and patients? 2%
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? YES
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: SCHEFFEL & COMPANY PC The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

GROUP HOME #3 #0037614 INSERVICE TRAINING JUNE 30, 2005

Description	Amount
JIM RICE FOCUS SEMINARS - ONE WEEK	\$ 731
ALL TYPE FIRE PROTECTION/SAFETY TRAINING	2
REIMBURSEMENTS	19
	<u>\$ 752</u>

SCHEDULE V LINE 23-3

BEVERLY FARM GROUP HOME #3 #0037614
REALLOCATION OF GH ADMINISTRATOR TO GH QMRP (DIRECT CARE)
6/30/2005

ACCOUNT #	DESCRIPTION	WAGES PER TB	RECLASS (OJE)	PER COST REPORT	HOURS PER SPREADSHEET		RECLASS		PER COST REPORT	
					REGULAR	VACATION	REGULAR	VACATION	REGULAR	VACATION
8250R0	GH 1 ADMIN	17,646.52	(7,058.61)	10,587.91	980.00	60.00	(392.00)	(24.00)	588.00	36.00
8250S0	GH 2 ADMIN	17,790.52	(7,116.21)	10,674.31	980.00	60.00	(392.00)	(24.00)	588.00	36.00
8250T0	GH 3 ADMIN	17,419.47	(6,967.79)	10,451.68	980.00	25.00	(392.00)	(10.00)	588.00	15.00
8250U0	GH 4 ADMIN	17,374.27	(6,949.71)	10,424.56	980.00	25.00	(392.00)	(10.00)	588.00	15.00
8250V0	GH 5 ADMIN	20,458.17	(8,183.27)	12,274.90	980.00	60.00	(392.00)	(24.00)	588.00	36.00
8250W0	GH 6 ADMIN	20,170.17	(8,068.07)	12,102.10	980.00	60.00	(392.00)	(24.00)	588.00	36.00
8252R0	GH 1 QMRP	-	14,174.82	14,174.82	-	-	784.00	48.00	784.00	48.00
8252S0	GH 2 QMRP	27,682.83		27,682.83	1,968.00	112.00			1,968.00	112.00
8252T0	GH 3 QMRP	25,134.00		25,134.00	1,968.00	112.00			1,968.00	112.00
8252U0	GH 4 QMRP	-	13,917.50	13,917.50	-	-	784.00	20.00	784.00	20.00
8252V0	GH 5 QMRP	30,178.12		30,178.12	1,992.00	208.00			1,992.00	208.00
8252W0	GH 6 QMRP	325.14	16,251.34	16,576.48	40.00	-	784.00	48.00	824.00	48.00
Totals:		194,179.21	-	194,179.21	11,848.00	722.00	-	-	11,848.00	722.00

There are three group home administrators. In the group homes that have a physical administrator office (#1,4,6), the administrator also serves as the QMRP. In those homes, 80% of the administrators' time is spent on QMRP duties.

GROUP HOME #3 #0037614
PAGE 20, SCHEDULE XVIII, LINE 33
JUNE 30, 2005

SERVICE	1	2	3	4
	HRS. WORKED	HRS. PAID	WAGES	HOURLY WAGE
SAFETY/RISK MANAGER	80	85	1,521	17.89
TRANSPORTATION	560	588	4,964	8.44
	640	673	\$ 6,485	

GROUP HOME #3 #0037614
VEHICLE DEPRECIATION - SCHEDULE XI., Section D.
JUNE 30, 2005

Use	Model, Make, Year	Cost	Current Book Depreciation	Straight Line Depreciation	Accumulated Depreciation
DIETARY	1994 FORD E350 VAN	1,551	-	-	1,551
TRANS	1995 CHEVY VAN	1,260	-	-	1,260
TRANS	1995 CHEVY CORSICA	503	-	-	503
TRANS	1996 CHEVY G30 VAN	1,813	-	-	1,813
SUPPLY	1996 CHEVY LUMINA	791	-	-	791
MAINT	1997 FORD PICKUP 4x4	707	-	-	707
TRANS	1996 CHEVY G30 VAN	730	-	-	730
TRANS	LIFT ON VAN	256	-	-	256
TRANS	CAR REPAIRS	208	-	-	208
MAINT	SPREADER	596	-	-	596
TRANS	1999 FORD E350 VAN	751	-	-	751
MAINT	1999 FORD DUMP TRUCK	1,200	-	-	1,200
MAINT	1987 GMC BUCKET TRUCK	450	45	45	450
TRANS	1999 FORD IDOT VAN	2,694	269	269	1,482
MAINT	1992 FORD F150 (Yellow)	330	66	66	231
TRANS	2001 FORD E350 VAN	1,709	171	171	598
TRANS	2001 FORD FOCUS	545	109	109	382
TRANS	1989 FORD BUS	400	40	40	100
TRANS	2002 FORD IDOT VAN	2,218	222	222	554
TRANS	2002 FORD IDOT VAN	2,218	222	222	554
TRANS	1996 CHEVY VAN	1,245	249	249	374
TRANS	CAR REPAIRS	197	39	39	59
TRANS	CAR REPAIRS	76	15	15	23
MAINT	1996 FORD RANGER	299	60	60	90
TRANS	2004 IDOT BUS VAN	4,384	877	877	1,315
MAINT	2004 F350 TRUCK	1,329	266	266	399
TRANS	1997 FORD E350 VAN	1,825	365	365	548
TRANS	BUS RENOVATIONS	259	52	52	78
TRANS	FORD E-350 VAN 15 PASS	1,369	137	137	137
TRANS	FORD E-350 VAN 15 PASS	1,462	146	146	146
SUPPLY	VAN MATS	11	1	1	1
TRANS	2005 GMC SAVANA VAN	1,415	141	141	141
TRANS	2005 GMC SAVANA VAN	1,417	142	142	142
TOTALS:		\$ 36,219	\$ 3,634	\$ 3,634	\$ 18,170